implement an automated claims processing and information retrieval system.

(2) The agency's request for a waiver must contain a written plan of correction specifying all steps it will take to meet the requirements of this section.

(3) The Administrator will review each case and if he approves a waiver, will specify its expiration date, based on the State's capability and efforts to meet the requirements of this section.

(f) *Prepayment and postpayment claims review.* (1) For all claims, the agency must conduct prepayment claims review consisting of—

(i) Verification that the recipient was included in the eligibility file and that the provider was authorized to furnish the service at the time the service was furnished;

(ii) Checks that the number of visits and services delivered are logically consistent with the recipient's characteristics and circumstances, such as type of illness, age, sex, service location;

(iii) Verification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed;

(iv) Verification that a payment does not exceed any reimbursement rates or limits in the State plan; and

(v) Checks for third party liability within the requirements of §433.137 of this chapter.

(2) The agency must conduct postpayment claims review that meets the requirements of parts 455 and 456 of this chapter, dealing with fraud and utilization control.

(g) *Reports.* The agency must provide any reports and documentation on compliance with this section that the Administrator may require.

(Secs. 1102 and 1902(a)(37) of the Social Security Act (42 U.S.C. 1302, 1396a(a)(37)))

[44 FR 30344, May 25, 1979, as amended at 55 FR 1434, Jan. 16, 1990]

§ 447.46 Timely claims payment by MCOs.

(a) *Basis and scope.* This section implements section 1932(f) of the Act by specifying the rules and exceptions for prompt payment of claims by MCOs.

(b) *Definitions.* ''Claim'' and ''clean claim'' have the meaning given those terms in §447.45.

(c) *Contract requirements*—(1) *Basic rule.* A contract with an MCO must provide that the organization will meet the requirements of §§447.45(d)(2) and (d)(3), and abide by the specifications of §§447.45(d)(5) and (d)(6).

(2) *Exception.* The MCO and its providers may, by mutual agreement, establish an alternative payment schedule.

(3) *Alternative schedule.* Any alternative schedule must be stipulated in the contract.

[67 FR 41115, June 14, 2002]

COST SHARING

§ 447.50 Cost sharing: Basis and purpose.

(a) Section 1902(a)(14) of the Act permits States to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. For States that impose cost sharing payments, §§447.51 through 447.59 prescribe State plan requirements and options for cost sharing, specify the standards and conditions under which States may impose cost sharing, set forth minimum amounts and the methods for determining maximum amounts, and prescribe conditions for FFP that relate to cost sharing requirements.

(b) *Definitions.* For the purposes of this subpart:

(1) *Indian* means any individual defined at 25 USC 1603(c), 1603(f), or 1679(b), or who has been determined eligible as an Indian, pursuant to §136.12 of this part. This means the individual:

(i) Is a member of a Federally-recognized Indian tribe;

(ii) Resides in an urban center and meets one or more of the following four criteria:

(A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;